DOCUMENT RESUME

ED 030 485 PS 001 934

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Disturbance and Dissonance - Community University Collaboration in Diagnosis and Treatment of Disturbances.

Boston Univ., Mass. Headstart Evaluation and Research Center.
Spons Agency-Office of Economic Opportunity, Washington, D.C.
Report No-OEO-4116
Pub Date 31 Aug 68
Note-21p.
EDRS Price MF-$0.25 HC-$1.15
Descriptors-*Community Programs, *Emotionally Disturbed Children, Health Programs, *Mental Health Clinics, Preschool Children, Preschool Clinics, Program Administration, *Program Descriptions, *Program Development, Program Effectiveness, Program Improvement
Identifiers-*Head Start

In 1967 the Head Start Evaluation and Research Center at Boston University initiated a project aimed at devising and assessing new clinical approaches to primary and secondary prevention of emotional disturbance in preschool children. The growth of "Black Power" plus a year of experience resulted in the making of several changes in the program in 1968: (1) the clinical activities were moved from the imposing offices at Boston University to suitable quarters in the heart of the black community being served; (2) the personnel involved were expanded to include not only parents, but key persons from the community involved; (3) all participants were converted to a fresh conception of what could be achieved in a given community by a more inclusive and coordinated effort. Thus, the project, as now structured, provides communities with the knowledge of how to handle emotional disturbances of young children within their own indigenous social system. (WD)

EDO 30485

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OEO 4116

Disturbance and Dissonance - Community University Collaboration in Diagnosis and Treatment of Disturbances

Boston University
Headstart Evaluation and Research Center
Under OEO Grant 4116
September 1, 1967 - August 31, 1968

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A. Outline of Project

The pilot project to be outlined in this report was initiated by the Headstart Evaluation and Research Center in the summer of 1967. At that time its stated scientific aim was to devise and assess new clinical approaches to primary and secondary prevention of emotional disturbance in pre-school children. An interdisciplinary team of psychologists, psychiatrists, and educators initiated a clinical research program to assess intellectual potential, diagnose and predict the course of abnormal affective states, and propose remedial or therapeutic measures whenever needed. As originally planned the team was to perform these various functions entirely within an institutional setting (the offices and observation rooms of the School of Education, Boston University) the team's practical purpose being to contribute to the success of those Head Start educational units with which it was affiliated. This practical aim was retained throughout the subsequent year of work; but the scientific aim--to devise and assess new clinical or instrumental procedures--was replaced by a different objective.

The chief focus of attention and effort that prevailed in the second phase had been partly anticipated at the outset when it was decided to enlarge the traditional structure of the professional team by incorporating teachers as equal members and giving full attention to the valuable information they were in a position to provide. By the end of the first summer, however, experience had already taught us that a much more radical change of organizational structure and purpose had somehow to be brought about if we were to function as effectively

as we judged we should and could. At this point we became engaged in the second phase of the project a year of action research which called for a logical progression of consequential changes: 1) moving clinical activities from the too-imposing offices at Boston University to suitable quarters in the heart of the community being served; 2) expanding the team to include, as active collaborators, not only parents but a number of key persons from the community in which the educational units were located; and 3) converting all participants to a fresh conception of what could be achieved in a given community by a more inclusive and coordinated effort. Thus, instead of attempting to devise improved clinical instruments and procedures, as initially planned, we found ourselves engaged in new organizational relationships and functions, in order to increase our resources of competent collaborating personnel, and second, to gain, as fully as possible, the acceptance, goodwill, and understanding of those whose welfare the project was designed to advance. The decisive importance of the positive or negative attitude of community leaders toward the on-going program became obvious during the winter of 1968 when the rise of Black Power threatened to bring the undertaking to a sudden halt; and the conclusion could hardly be avoided that if we had stuck to our primary intention to polish up our clinical tools we would have ended up without children.

Our target population consisted of two groups of preschool children, one from the inner city and one from a middle class neighboring suburb with a relatively stable population. The children in the inner city came from several Headstart classes, those in the suburb from a summer public school pre-primary program.

The project was instigated and coordianted by the Boston University Head Start Evaluation and Research Center. Faculty and students from the schools of Education and Medicine participated. The Headstart group was coordinated by the South End Neighborhood Action Program (SNAP), a delegate agency of Action for Boston Community Development (ABCD), an inner city community action programs financed by the Office of Economic Opportunity. The suburban group was coordinated by the staff of the local public school system, including a school adjustment counselor, and by the local community mental health clinic. A description of the communities and procedure of this summer's project, started in 1967, is covered in detail by Fish et.al. Report of Research, 1967.

In the summer of 1968 the two communities, on the one hand the inner-city, low socially and economically, inter-racial and inter-ethnic, and on the other hand, the suburban community, lower middle class, relatively uniform and stable, historically "traditional yankee" were again asking for clinical services, but in each community basic changes had occurred.

The political climate had changed in the inner city. The mood of the city had turned from one of passive acceptance of aid to one of aggressive independence with a clamoring for autonomy. The question of race and racial identification had become a dominating theme. It was no longer a simple matter of inviting the South End centers to work with us but was instead a process of waiting to be included in the on-going dynamics of local power struggles.

The suburban community was also undergoing change. Rather than strengthening the internal organization of the community, it was feeling a breaking up of an old solidarity. In one year, the population had increased five per cent. New ethnic and religious groups were settling in the area.

The study of these communities, their existing patterns of coping, and the creation of new patterns, demanded extensive community involvement which continued throughout the planning, implementation, and evaluation of our program. The initial focus had been on children of particular parents, in a given community, being seen by a professional team in a University clinic setting where procedures were limited by previous training and experience. Resulting disparities between observations, diagnostic findings, follow up and consequent multiple and inconsistent standards lead to the development of a new model for investigation. The interest was now in the integrated concept of community-family, not the family-child unit as the source of understanding deviant behavior of children.

B. Theoretical Considerations

The moment it was evident, as explained earlier, that the operations of the clinical team could not be effectively performed without close cooperation of parents of children--many of whom were initially distrustful or definitely antagonistic--, and later the moment we were faced by the fact that clinical functions could not be performed at all without the consent of certain leaders in the black community, it became absolutely necessary for us to focus on those features of the social situation which threatened survival of the project. Thus, we came to conceive of our immediate undertaking as action research in the domain of social psychology, rather than technical research in the area of clinical psychology. The task was to move from discord and dissent to concord and assent, or, to use Festinger's (1967) terms, from dissonance to consonance. Festinger's primary interest was in the discomfort produced by a person's awareness of the existence in his mind

of two dissonant (opposing, conflicting, inconsistent) cognitive elements (beliefs, opinion, values, aims), and the various mental manoeuvres that are commonly adopted to diminish the existing dissonance and thereby to approach a sufficiently comfortable state of consonance. Festinger found that his theory was also applicable, in large measure, to changes from dissonance to consonance in a generally harmonious group. Since this was the very change which we attempted to bring about in the communities we served and which actually occurred to a significant extent, it was to Festinger that we turned for possible theoretical formulations.

Festinger shows that cognition, or the awareness of external realities, helps a group strive towards consistency and congruity. Individuals and Social Groups attempt to maintain this consistency in opinions, attitudes and values among the members and keep a close relationship between their beliefs and action. However, in every ongoing situation inconsistencies necessarily arise and with inconsistencies come psychological discomfort. Festinger's basic hypothesis, is that the existance of this discomfort, or dissonance, being psychologically uncomfortable, will motivate a group to try and reduce dissonance and achieve consonance whether it is within the group, between groups, or both. Every group is constantly aware of dissonance because new events, new information and the relativity of life all add up to a conglamoration of contradictions and choices.

To reduce dissonance one attempts to change behavioral activities that do not fit into the cognitive schema, change environmental cognitive elements, or add new cognitive elements. Resistance to dissonance reduction occurs if new ideas are too painful, incur too great a loss of other ideas and values, or if

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present behavior is satisfactory enough and separation between elements is not too great.

In spite of resistance to dissonance, decisions are made and the consequence of these decisions are significant because they necessitate rejecting something of value. The group has to restructure and re-value alternatives.

After the decision with its consequential dissonance, there is a drive to reduce new dissonance. An attempt is made to increase the relative attractiveness of chosen alternatives, decrease the relative attractiveness of unchosen alternatives and establish cognitive overlaps. Festinger's data show that following a decision there is active seeking-out of information which produces cognitive consonance with action. He showed that it was difficult for groups to reverse decisions once they had been made because resolution of dissonance had been actively going on.

The social group becomes the major source of cognitive dissonance and, at the same time, the major vehicle for eliminating and reducing the dissonance. It is the social group that introduces conflicting values and it is within the social group that one seeks support for chosen alternatives. Therefore, the processes of social communication and social influence are inextricably interwoven with the processes of creation and reduction of dissonance and its resulting social change.

In the proposal for an interventional program presented by Dr. Frank Garfunkel in July, 1968, he discussed the intimate relationship between status and learning, showing that a status discrepancy usually separates the teacher and the student and consequently hinders learning. He argues that the most successful teaching and learning situations from pre-school to University take place when

teachers status is equal to or less than that of students. The procedures of our project evolved from the consideration of this status imbalance and the double standard to which it has presumably lead, and attempted to minimize imbalance. But what became increasingly clear was that status imbalance could be used to promote greater change in rigid scholastic and social systems.

The question of status imbalance became a useful tool to deal with the problems of decision making and social change. This project appropriated theories of dissonance to find areas of psychological discomfort and to discover areas of overlap in dissonant constellations. We tried to reduce dissonance between factional groups, such as, the inner-city, activist segregationalist black-power groups, the University, non-professionals and white middle-class groups as well as dissonance among professionals. With this simple consideration in mind, the enormity of the task at hand became manageable and comprehensible, and movement towards social and behavioral change became apparent.

At the outset of the program the most consonant group was the Professionals. Their initial goals, with a common clinical interest and long-term allegiance had united them into a relatively cohesive group.

The first summer teachers had a difficult time comprehending analytic theory as it was articulated by psychiatrists and social workers but by working out the problem, usually semantic, through the diagnostic process and having children

constantly at hand to observe, corrections and explanations led to consonance. We were able to bridge this jargon gap without too much difficulty. The real discomfort came when we tried to communicate with the members of the inner-city community.

Since the ideas and procedures of our intervention could no longer be presented to the community for their approval but rather had to grow from a dialogue that had been going on for past two years, individuals and agencies in the community had been and continued to be involved both formally and informally in the interventional program.

The first major introduction of dissonance in the professional group was in the expansion of the concept of a "professional". A professional is usually seen as a credentialed person with trained skills, but we began to define a professional functionally. In other words we were including "new" professionals. We had credentialed staff, but we needed skilled persons to communicate with us from the community, about the community. We began selecting and training such community professionals.

The Evaluation and Research Center had been involved in training individuals from the community as research assistants. The process of involvement in the case of individuals hired on a formal basis, had included the following stages:

a. recruitment and screening

b. training and interviewing, observation, case finding, testing and teaching.

c. second stage of screening, search for special skills from individuals who go through initial training programs.

d. assignments to various parts of the Evaluation and Research Program in connection with proven skills.

e. assignments to special projects in accordance with individual talents to work with individuals, or groups. Dealing with recording data, creating materials for the research or the teaching programs.

f. selecting individuals to matriculate for degrees at the university.

Other community persons outside of this sreening were employed as senior consultants because of their demonstrated ability to deal with problems connected with community organization and education. These community consultants worked closely with University staff recruiting other individuals from the community and initiating dialogues on the total educational and mental health processes in the community.

Once involved with these community consultants, the team professionals began to lose some of their professional identity and immerse themselves more deeply in community problems. At the same time, the community people began to identify themselves as professionals in professional roles. There was, indeed, a degree of overlap of cognitive elements in mutual commitment as suggested by theory. As a result of this new emerging concept of professionalism the boundaries of traditional professions were defused and professionalism became associated with proficiency and knowledge in producing pragmatic activity. The dissonance between

the original university team and the community was directed towards consonance by extending group membership. Once a member of the Professional Team, the new community person, to reduce discomfort of giving up alternatives, gave high value to chosen aims.

An example of diffusion of roles and the extent of parent involvement happened half-way through the summer. Parents who were involved professionally with the group as consultants, secretaries, and observers, asked the team to conduct a session evaluating their children. They indicated that there were no pressing problems but they had been excited and interested in diagnostic procedures, and wanted to see how their children would behave in such a situation. Parents also wanted to try out their new professional insights learned from the procedures of the summer acting as part of the diagnostic team.

We ran a double session to let their children experience the entire diagnostic procedure. After seeing these children the question came to mind: Why did these children from the same setting, with much of the same trauma that had been experienced by parents of disturbed children, have such obvious strength? They were not only high on all intelligence and cognitive ratings but were adjusted, learning efficiently, curious and competent.

An exciting result was the experience of one mother who had come to us originally as a community consultant. Her child had attended the extra-experimental diagnostic session. She had attended all staff meetings and had become so involved and interested in the entire diagnostic-referral process that she is training for the new role of "community therapist", using the knowledge she learned this summer and continuing supervision.

At the end of the first summer it had been clear that one of the main problems was the dissonance between parents and professionals. Professional-parent dialogue, community leader-parent dialogue and neighbor-parent dialogue were discussed as to the relative merits of these types of communication and their relationship in helping children. We knew we had to find new ways to reach parents so they could profit from the partnership with education and research staff in the education of their children. So as far as the diagnostic procedure was concerned, we knew every opportunity had to be given to the parents to be part of the process. They had to be included in the observational sessions of the class. They were also to be visited in their homes by professional members of the clinic staff as well as by community representatives and consultants. The project would fail if the alternatives resulting from the intervention could not be communicated to parents.

A subtle but significant change in the project was to relocate the headquarters and make the control center in the inner city itself. Following the modified plan based on the original diagnostic class that had formerly been held in the University, a new facility was developed in the basement of a church. This consisted of two large classrooms with oneway glass and two observation rooms of ample size, providing not only room for the diagnostic class but a setting for individual testing of children which could be observed by parents and our new roster of professionals. By placing facilities within the community, parents found it convenient to visit and take part in diagnostics workup of their children. The previous summer few parents had come to the distant University and if they did come, found it a threatening and overwhelming place. Those parents who had not come but had sent their children were suspicious and concerned about the welfare of their children. We were able to narrow this gap

of fear and dread by increasing our visibility. The church is a strong, central, long-established unit in the community. The staff of the research center, the professional teams and the community consultants were soon familiar to many of the residents of the area. As the teams visited the schools and homes, they invited participants to the church and the parents began to trust the procedures more, and commit themselves to the project.

To increase membership in groups is not as difficult as to gain relevancy between two markedly antagonistic groups. As the racial identification of Blacks increased in power during the winter of 1967-68, the split between the University Research Teams and Community Leaders was acute.

A critical point came when the Black Community challenged the Clinic staff on the relevancy of diagnostic testing for their children. The Blacks felt, with justification, that intelligence tests were primarily standardized on middle class whites. They were also highly suspicious about projective techniques being used on their children.

The Clinic staff invited any interested members of the community to come to the University Psycho-educational clinic where there were observational facilities, and to bring any child they wanted to be tested. About thirty came. On arrival, they were openly hostile. The staff arranged for three demonstrations of testing on several of the children that accompanied the adults: Rhorschach, Porteus Mazes (for qualitative scoring as opposed to I.Q. scoring) Draw-a-Person, Stanford-Binet and a diagnostic evaluation of group activities. Before and

after each testing the examiner explained the tests and the results. The emphasis of the examiners in the dialogue was on the dynamics of child - development rather than on quantitative aspects of testing.

The first child examined was a lively, appealing six year-old with a vivid imagination. The presence, and obvious enjoyment of the child in the testing process, was the initial link between angry parents and the clinic staff. The second examiner was a young soft-spoken Negro woman with whom the Blacks could identify. The rolicking play of the diagnostic group added humor to the interplay of forces. Discussion centered throughout on how testing results could help the child in the school and help the parents with the child. By the end of the session, anger and resistance had dissolved and the Blacks agreed that diagnostic testing could be helpful and invited us to continue our work in the community, pledging their help in running and backing the summer program. Once their decision was firm, the Blacks were loud in their acclaim of the relative attractiveness of the chosen alternatives.

Another example of initial inter-group dissonance was between the inner city community and the suburban community. The summer before, the suburban group had been enthusiastic and energetic in their commitment to diagnostic processes at the University. Many teachers and parents came to observe diagnostic classes. Interest in the pre-primary program and the Diagnostic Clinic spread to principals and the superintendent of the suburban elementary schools.

We were concerned that this stable lower-middle class white group would be fearful of coming into the city when rumors were running high on the explosive nature of summer city people. We had also been warned by the minister of the church that his people might object to the presence of suburban white children and teachers in their midst. It was becoming increasingly clear that black identity meant black power and black segregation.

We approached our new integration project, therefore, with a good deal of concern. What we had not estimated fully was the degree of commitment that each community had made to the program before it began. In the suburban community recommendations for individual children from the proceeding summer had proved effective. In the inner city community consultants had integrated us enough into the community process so that we had their backing. Just as Festinger had predicted, each side, once they were commited to the program, began to see in the other group things they liked and to re-adjust prior biases.

Discussions in afternoon staff meetings were lively and humane. It was of particular interest that the one negro teacher in the suburban schools rarely missed any of the sessions, bringing her child with her to play with other children.

Interestingly, the suburban community raised no objections to the new location in the heart of the city, in spite of difficulties in transportation and the inherent difficulties of bringing middle-class white children into the ghetto community. The South End community began to see this as a shift from expected procedures. For once, they were not being "sent out" to get help but had indigenous health facilities and were in a position to invite others "in".

C. Clinical Process

As consonance was increased on all levels, we could enjoy the evolving clinical process. Parents and other community people were involved in planning the diagnostic program and in determining roles to be played by credentialed and non-credentialed professionals. Selection of cases for review came from a broader base than the summer before, including follow-up cases already in progress, an increased number of referrals coming from children not yet in Headstart but from high-risk families, and children who were coming in through screening process done by observers in Headstart classrooms as well as referrals. [1]

The procedures used for screening and diagnostics were simple. In the suburban community, children were referred from the pre-primary system by teachers or by observers from our staff or from the pupil personnel in the school system. From the inner city, children were screened through the local neighborhood action program, Head Start programs, the Child Welfare Office and other cooperating agencies such as Family Service, and Division of Child Guardianship. Teachers were asked to observe all children and refer those about whom they had questions. The diagnostic team consisting of psychiatrists, psychologists, master teachers and speech and hearing experts, observed all classes in both areas, as part of the initial screening process.

[1] In the inner city community a total of 23 children were referred, 15 boys, 8 girls. Of these, 17 came in for the full diagnostic work-up, 10 boys, 7 girls. From the other community, a total of 19 were seen, 13 boys, 6 girls, and 8 had full work-ups, 6 boys, 2 girls. Total N = 42 (28M, 14F)

When a child was seen as problematic, parents were consulted immediately. When possible, parents and teachers conferred before permission was sought to include children in the diagnostic workup. Teachers had the option of asking neighborhood workers or any member of the diagnostic team to confer with the parent. If parents wanted to have a diagnostic workup of their child, they were asked to indicate this in writing and, when applicable, to sign a release permitting the University to request social and medical histories.

Procedures for the workups included an interview of the teacher. A verbatim statement was made by teachers about their concern for the child. Each teacher was asked to describe her attempts to deal with problems and to make statements about what she wanted from the diagnostic team in the way of help in solving the problem. The class setting was also described - the facility, location, hours and number of children in the class and number of adults and other features of the class. The daily routine was listed and the child's functioning in the class described from the point of view of dynamic psychology and with the Classroom Behavioral Scale.

All parents were interviewed on the child's developmental milestones and child rearing practices. General social conditions in which the child lived were noted. Individual testing was done on each child by the psychologist. The routine test was the Binet but projectives and perceptual tests were also given. If there was any suspicion of speech difficulty the speech and hearing team conducted their own specialized tests.

Diagnostic nursery sessions were held for those children who were not able to adjust in the classroom after the consulting teams had made suggestions and the teacher had tried to work them out. These sessions were for two afternoons in the week for two hours in the afternoon. The diagnostic teacher and her aid conducted the class while the staff and parents observed in the observation room. On the third day the staff met for the entire afternoon with the teachers, social service personnel and community consultants to staff each child and drawup recommendations for the family and teacher. A separate prediction on each child was made for future reference but was not included in the child's working file.

The child was then followed-up in class. A member of the team took the recommendations directly to the teacher explaining them to her. Support was given throughout the rest of the school session to the teacher in her relationship with the child. Similar steps were taken with the parents.

The aim of the diagnostic nursery sessions was less to teach children than to organize activities in such a way as to stimulate the childrens' behavior and to note his style of functioning in different situations. In organizing the program therefore the teacher kept the following considerations in mind:

1. Free versus structured activities.
2. Group versus individual activities.
3. Comparison of children's use of freedom and control during the two sessions.

In the diagnostic classroom we grouped children in a new way not usually considered in classes in conventional settings. In the first place we had the children divided across to class lines. We also tried to keep the balance between boys and girls and there was a considerable age span in the children as they came in. No attempt was made to place children according to etiology or diagnostic category.

Instead of running a typical battery of tests on the children in isolation, we invested time on observing the child in his school and home setting. We were then aware of each child's specific difficulties and could space the teaching style and tasks according to the child's needs. This put a considerable amount of strain on the ingenuity of the teachers but provided critical diagnostic information. Experimenting with cognitive function tests such as those evolved by Piaget was an integral part of the class. A student of Piaget's demonstrated testing cognitive operations in a child with no speech. Two children raised in Spanish speaking homes, with no verbal fluency came in to diagnostics. Unexpectedly, the boy that looked mature psycho-sexually had primitive cognitive functioning, whereas a little girl, withdrawn and distant, did logical cognitive tasks with facility and obvious eagerness.

Since the close of summer diagnostics we have had emergency calls on two children. The situations were handled according to our recommendations but were checked in order to make sure that they were on the right track. Teachers now have confidence and assurance that offered alternatives are workable.

D. Some Implications for the Future

Our aim, that emerged as we changed the structure of the organization, had been to provide communities with a knowledge of handling emotional disturbances of young children within their own indigenous social systems. In both communities, as a direct result of the long dialogue and resulting interventions, a mobilization of community resources occurred.

School officials agreed that childrens' problems could be identified early and were ready to accept innovative ways to provide needed help. The key coordinator from the pre-primary program, an elementary school adjustment counselor, who had worked both summers with us, organized volunteer high school boys and girls into "big brothers" and "big sisters". These students were originally supervised by a consulting psychologist from an affiliate clinic. Our diagnostic recommendations were followed. This program has mushroomed. There are now one boys' group and two girls' groups supervised now entirely by the school guidance counselor acting as catalysts in the treatment program. The children they see no longer come from our small case load, but include any child the teachers find difficult and in need of help.

The diagnostic center continues in the church. The community therapist is assisting the regular staff in moving out into the community, helping on follow-ups and crisis intervention. As a result of our summer findings, a transitional class has been set up to take care of children currently excluded from school. Hopefully, the presence of this class will provide pressure (dissonance) on the Boston Public Schools to incorporate this class model into the system.

E. Summary

The primary purpose of the Headstart Evaluation and Research Center was to provide diagnostic facilities for two differing communities to promote primary and secondary prevention of emotional and intellectual disturbance. This continued throughout the project, but interest in clinical tools and procedures became less important than helping the communities to identify their particular problems and to provide alternative ways of dealing with them. Leaders from the communities were identified and trained to act as agents of change. Providing immediate clinical services from the University to the community acted as a vehicle for reaching and teaching community agents. Attempts were made to identify high risk groups and operationalize theory in dealing with these problems.

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